IDAHO MEDICAID SURGERY AND MEDICAL TREATMENT PRIOR AUTHORIZATION REQUEST

To Requesting Provider: Please complete form, attach required documentation and return

PRIOR AUTHORIZATION REQUEST FORM

Today's Date:	Proposed date of Service:
Participant:	Hospital:
Medicaid ID #	Inpatient ☐ Outpatient ☐
DOB:	
Phone:	
Requesting Provider:	Surgeon:
Address:	Address:
City/Zip:	City/Zip:
Phone:	Phone:
FAX:	FAX:
Provider Medicaid ID #	Provider Medicaid ID #

Procedure Description and CPT Codes _____

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Additional Comments _____

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Supporting documents required, please attach the following: (mark all items attached)

- ☐ **History and Physical**
- ☐ **Consultations**
- ☐ **Provider/Surgeon Notes**
- ☐ **Treatment Plan**
- ☐ **History of Disease**
- ☐ **Present Condition**

Mail or Fax to:
ATTN: Leanne Lundquist, RN

Division of Medicaid
Surgery-Treatment Reviews
PO Box 83720
Boise, Idaho 83720-0036

Phone 208-364-1954
Fax 208-332-7280